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AMENDMENT NO._____

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Signature of Sponsor

AMEND Senate Bill No. 1587* House Bill No. 1785

by deleting all of the language following the enacting clause and by substituting instead the following:

SECTION 1. The provisions of Tennessee Code Annotated, Section 56-32-210, is deleted in its entirety and the following new provisions are enacted instead:

(a)

(1) "Covered person" means a person entitled to receive benefits or services under a health maintenance organization.

(2)

(A) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding:

(i) Availability or delivery of health care services;

(ii) Claims payment or reimbursement for health care services; or

(iii) Matters pertaining to the terms and conditions of the contractual relationship between a covered person and the health maintenance organization.

(B) A grievance does not include inquiries about any of these matters.

(b)

(1) A health maintenance organization shall maintain written documentation regarding grievances containing, at a minimum, the following information:

(A) A category generally describing the reason for the grievance.

(B) Date received;

(C) Date of review;

(D) Resolution of grievance;

(E) Date of resolution; and

(F) Name of the covered person for whom the grievance was filed.

(2) The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

(3) The grievance register shall be retained for the longer of three (3) years or until the commissioner has adopted a final report of an examination that contains a review of the grievance register.

(4) Each health maintenance organization shall submit to the commissioner an annual report, in a form prescribed by the commissioner, which shall include:

(A) A description of the procedures of such complaint system;

(B) The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed; and

(C) The number, amount and disposition of malpractice claims made by enrollees of the organization that were settled during the year by the health maintenance organization.

(5) The information submitted by a health maintenance organization pursuant to paragraph 4 shall not include any consumer identifying information or information considered confidential under state and federal laws.

(c) A health maintenance organization shall use written procedures for receiving and resolving grievances from covered persons.

(1) The grievance procedure and any material modifications thereto shall be filed with the commissioner for approval. Upon request, supporting documentation shall be filed with the commissioner. In addition, the health maintenance organization shall file annually with the commissioner a certificate of compliance. The certificate must state that the health maintenance organization has established and maintains grievance procedures that fully comply with the provisions of this section.

(2) A description of the grievance procedure shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

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(3) The grievance procedure shall include a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the telephone number and address of the commissioner.

(4) In response to an inquiry from a covered person regarding a denied claim, which inquiry is not a grievance, the health maintenance organization shall provide an outline of the grievance procedure and the covered person's rights to seek review by the commissioner pursuant to subsection (e).

(5) A grievance review committee shall be established by the health maintenance organization. The committee shall not include a person whose decision is being appealed or who made the initial determination denying a claim or handling a grievance. The review shall be held within ten (10) working days of receipt of the grievance and all necessary information; provided this time may be extended by written notice to the covered person that review cannot not be accomplished within ten (10) working days, such extension not to exceed an additional ten (10) working days. The health maintenance organization shall provide to the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health maintenance organization upon receipt of the grievance.

(6) The covered person is entitled to submit written material and may have the assistance of an uninvolved member of the staff. The health

maintenance organization shall make these rights known to the covered person upon receipt of the grievance.

(7) A written decision shall be issued to the covered person or the covered person's representative within five (5) working days from the date of the review. The written decision shall contain:

(A) A statement of the grievance committee's understanding of the covered person's grievance;

(B) The committee's decision in clear terms of sufficient detail including the contract basis or medical rationale for the decision; and

(C) A reference to the documentation and information used as the basis for the decision.

(8) The procedures described in (5) and (7) above shall not apply to emergency or other situations where failure to provide health services promptly is likely to cause substantial harm. The health maintenance organization shall establish a procedure to deal with such grievances on an expedited basis.

(d) A covered person may request that the grievance review committee reconsider its initial decision by notifying the health maintenance organization in writing within thirty (30) days of receiving the committee's written decision. Upon receipt of such a request, the committee shall reconsider the grievance in accordance with the requirements of subsection (c). A covered person may submit, for the committee's consideration, additional written material pertinent to the grievance.

(e)

(1) After receiving either the initial decision by a grievance committee, or a decision upon reconsideration by a grievance committee, a covered person may seek review of the matter by the commissioner or a designee of the commissioner. The commissioner or the commissioner's designee may consult with medical personnel in the department of health for grievances that involve primarily questions of medical necessity or medical appropriateness. Such review by the commissioner or designee shall be initiated by the covered person's submitting to the commissioner and the health maintenance organization a written request for review within thirty (30) days of the date of either the initial decision or decision on reconsideration by a grievance committee. The commissioner or designee shall review the file of the health carrier and any other information submitted by either the health maintenance organization or the covered person.

(2) The results of the review by the commissioner or designee shall be in written form and a copy thereof shall be provided to both health carrier and the covered person. Review by the commissioner or designee in accordance with this subsection (1) shall not be a contested case under Tennessee Code Annotated, Section 4-5-301, and (2) shall not preclude either the covered person or the health maintenance organization from initiating judicial proceedings. The

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results of the review by the commissioner or designee shall not be admitted as evidence in any judicial proceeding.

(f) This section does not apply to the TennCare program, which operates under a Federal waiver pursuant to Tennessee Code Annotated, Title 71.

SECTION 2. This act shall take effect on January 1, 1998, the public welfare requiring it.